DEPARTMENT OF GENERAL SERVICES
MARYLAND CAPITOL POLICE

LONG TERM ILLNESS/INJURY CALL IN REPORT FORM

DATE: _____

EMPLOYEE NAME: _____ _____

NAME OF PERSON TAKING REPORT: _____ _____

INJURY OR ILLNESS: _____

_____

_____

WAS EMPLOYEE INJURED AT WORK YES ☐ NO ☐

IF SO WHAT IS THE IWIF CLAIM NUMBER? _____

HAS EMPLOYEE BEEN SEEN BY A DOCTOR: YES ☐ NO ☐

WHEN WILL THEY BE SEEING A DOCTOR: _____

APPROXIMATE LENGTH OF ABSENCE _____

IS THE EMPLOYEE USING PAID LEAVE TO COVER ABSENCE? _____

EMPLOYEE'S CURRENT SICK LEAVE BALANCE _____

SIGNATURE OF EMPLOYEE'S SUPERVISOR _____

SIGNATURE OF DETACHMENT COMMANDER _____

SIGNATURE OF HEADQUARTERS
SICK LEAVE COORDINATOR_____

(IF SWORN PERSONNEL SICK LEAVE BEYOND 30 DAYS, TRAINING COORDINATOR MUST BE NOTIFIED) Date Notified: _____

FOLLOW-UP DUE DATE: _____

cc: Supervisor File
MCP Personnel File
Lisa Hall, Department of Personnel